MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Princeton Pain Management 3710 Rawlins Dallas, TX 75219	MDR Tracking No.: M4-03-7458-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 19 Fidelity & Guaranty Ins. c/o Flahive, Ogden & Latson 505 West 12th St. Austin TX 78701	Date of Injury: Employer's Name: Cracker Barrel Old Country Store Insurance Carrier's No.: 645C170656

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/31/02	11/8/02	97799-CP	$1,526.00	$0.00
12/18/03	12/18/03	97750	$516.00	$0.00
12/18/02	12/18/02	90899	$90.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

5/1/03: "Please find enclosed…unpaid bills for services rendered…remain unpaid…for all the…DOS, the carrier denied our bills for "A-preauthorization not obtained. We obtained…and a copy…is enclosed…For DOS 12/18/02, the carrier denied…"N" and "F." We are within the fee guidelines and everything was documented therefore: reimbursement is due for this DOS. All of these DOS have been submitted for reconsideration…carrier…has chosen to continue denying…despite clear evidence that their denials are inaccurate…I have included copies of all medical documentation, as well as relevant rules to support our position…"

PART IV: RESPONDENT'S POSITION SUMMARY

7/3/03: The respondent made a note on the TWCC 60 that "Carrier will re-audit and pay."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT Code 97799-CP for dates of service 10/31/02 through 11/8/02 were denied "Chronic Pain Management, A-Preauthorization required but not obtained."

- A copy of the preauthorization from REM Managed Care, indicated "This is to confirm our conversation with you or your office staff on 10/18/02 regarding…claimant. We are able to certify the treatment(s) Chronic Pain Management Program… (10) ten visits. #020919-004." Therefore, preauthorization issue is moot.
- The requestor did not submit convincing evidence to support their usual and customary charges according to 133.1 (a)(8) and MFG/GI VI, therefore no additional reimbursement can be recommended.

CPT Code 97750 (12 units) for DOS 12/18/02: denied "N – Not appropriately documented. Report submitted does not appear to substantiate level of service billed. No MT documented."

- The assorted pages 32 through 45 were submitted but a written report was not received to review. According to the MFG/ MGR (I)(A)(9) under the title, 'Note: Tests and measurement codes -97750 require a report of the results, and no additional reimbursement shall be allowed for this report.' Also, according to the CPT descriptor for 97750 a written report is required. Supported convincing evidence was not received for review, therefore reimbursement can not be recommended.
- CPT Code 90899 (MFG descriptor: Unlisted psychiatric service or procedure) for DOS 12/18/02 was denied "F- Fee guideline MAR reduction. This procedure does not appear to be within the scope of your license." According to the MAR, this CPT code is to be supported with DOP. No documentation was received for this DOS. Convincing evidence was not received for review to substantiate this service rendered, therefore reimbursement can not be recommended.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

Authorized Signature	Typed Name	04/13/05 Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____